Step 6: Track MNT Services and Reimbursement

"We are proactive and visible RDs at the Santa Fe Service Unit. Administration expects us to maximize our resources and deliver high quality care to our clients."

– CAPT Leeanna Travis, RD, MS, MA, CDE
Santa Fe IHS

Tracking MNT services and reimbursement provides a wealth of information for you and your MNT practice. You should consider developing or adopting a tracking system that will help you record patients' visits, the MNT services that you provide, and reimbursement for MNT services. (Please refer to Appendix C for a sample tracking form.)

What are the benefits of tracking MNT services and reimbursement?

A tracking system for MNT services and reimbursement offers a number of benefits. First, it can help you avoid common mistakes that may affect claim reimbursement, such as a missing PIN or misspelled name of the beneficiary. Second, it can help you avoid exceeding the number of billable hours allowed for initial and follow-up visits. This will also help improve billing office efficiency by ensuring that they do not submit MNT claims for services that have exceeded the billable hour limits of Medicare. Finally, your billing office may need to submit your claim several times before your claim is paid. A tracking system can help you follow the resubmission process and ensure that your billing office is aggressive about seeking payment for your claims.

What questions should my tracking system address?

Your tracking system should address the following questions to ensure that claims are submitted properly:

- Were the correct MNT CPT codes, time units, and indication of individual or group visits properly entered?
- Were the UPIN for the treating physician and RD PIN correctly entered?

- Was the diagnosis code included?
- Does the patient qualify for the Medicare Part B MNT benefit? (i.e., Was the patient enrolled in Medicare Part B and have the qualifying criteria for the MNT service?)
- How many hours of MNT were provided?

What should a good tracking system include?

A good tracking system should include the following information:

- Dates of service.
- Patient s initials and/or medical record number.
- An indication that the treating physician referred the patient.
- Type of coverage (e.g., Medicare Part B or private insurance).
- Diagnosis and ICD-9 codes.
- Service provided, minutes of service, and MNT CPT code.
- Dollar amount and percent of charge reimbursed.
- RDs who provided MNT services to the patient.
- Setting (e.g., clinic or hospital) that submitted the claim, if the location of your services varies.
- Comment section to document additional information, such as why a claim was denied, why a claim was not submitted, or what action you have taken on a claim (e.g., resubmitting the claim with corrected or additional information).

Most IHS claims are electronically submitted. The turn-around time for accepted claims is minimal, usually 14 days. However, it may take more time for you to be notified if your claim has been denied for payment.

If the claim is denied, the billing office is responsible for following-up on each unpaid claim to ensure optimal reimbursement. Depending on the reason for the denied claim, the billing office will notify the Medicare fiscal intermediary or review the existing supporting documentation to resubmit the claim for payment. This step is critical, and needs to be performed within the timely filing limits set forth by the Medicare fiscal intermediary. Otherwise, the Medicare fiscal intermediary will not consider the claim for payment. (Please refer to Appendix A for the top ten documentation errors that can lead to a denied claim.)